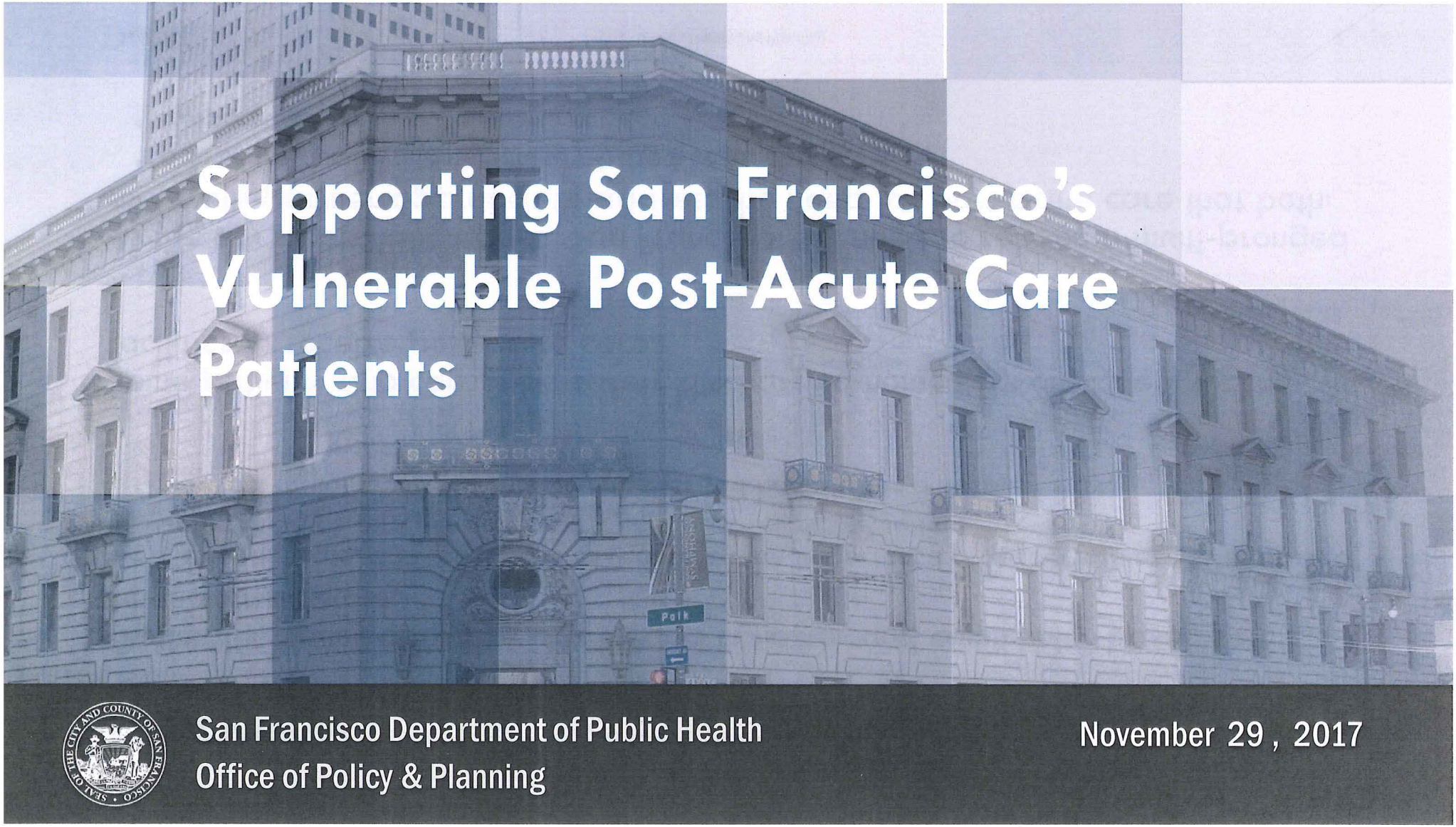
Presented in Committee - November 29, 2017



Supporting San Francisco's Vulnerable Post-Acute Care Patients

San Francisco Department of Public Health
Office of Policy & Planning

November 29 , 2017

Overview

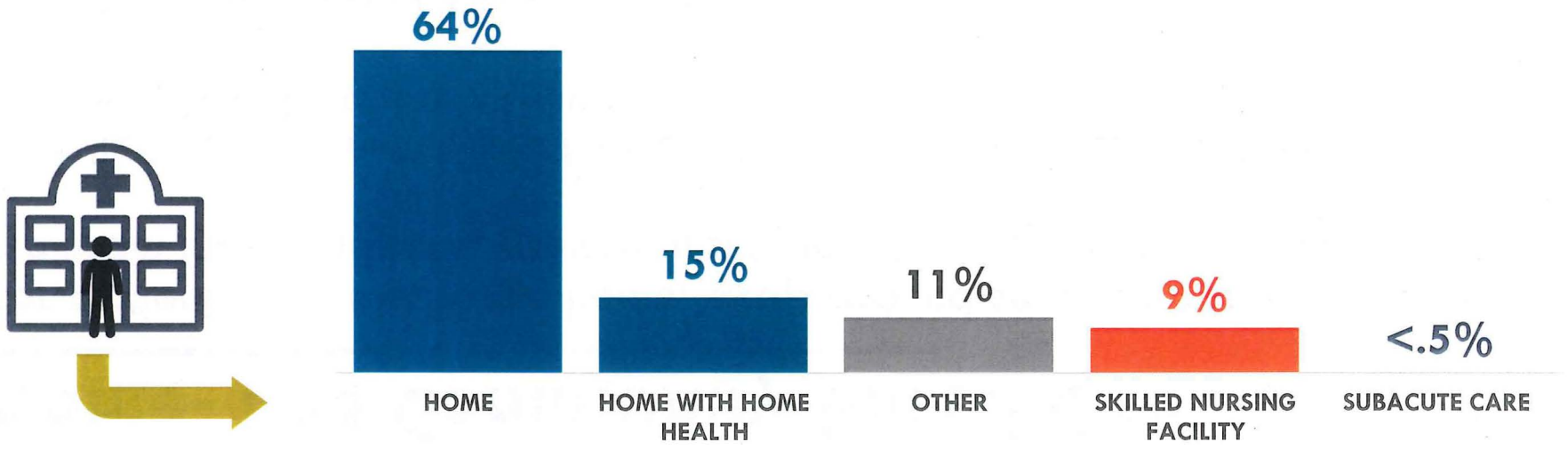
- Optimally, post-acute care is provided in home- and community-based settings whenever possible.
  - National, state, and local policies recognize the importance of aging in place to maximize independence and provide care in the least restrictive setting.
  - The vast majority of patients are discharged home after a hospital stay.

- Some patients who cannot be safely discharged home rely on skilled nursing facilities to receive post-acute care.

- As the city's population ages, San Francisco will need to rely on a multi-pronged and multi-partner approach to address the need for post-acute care that both:
  - prioritizes home- and community-based care, and
  - supports access to skilled nursing beds.

Some Patients Discharged from a Hospital Need Continued Care

Hospital discharge patterns are consistent on the national and local level



Home- and Community-Based Care

For patients who discharge home, wrap around services are essential to maintain independence, prevent institutional care, and age in place.

- Residential Care Facilities for the Elderly provide 24/7 supervision and assistance with Activities of Daily Living

- The Department of Aging and Adult Services supports programs that bridge the gap between acute and community-based care settings through programs that include:
  - In-Home Supportive Services
  - Community Living Fund
  - Case Management
  - Home Delivered Meals or Groceries
  - Transportation
  - Caregiver Support

Post-Acute Care Overview

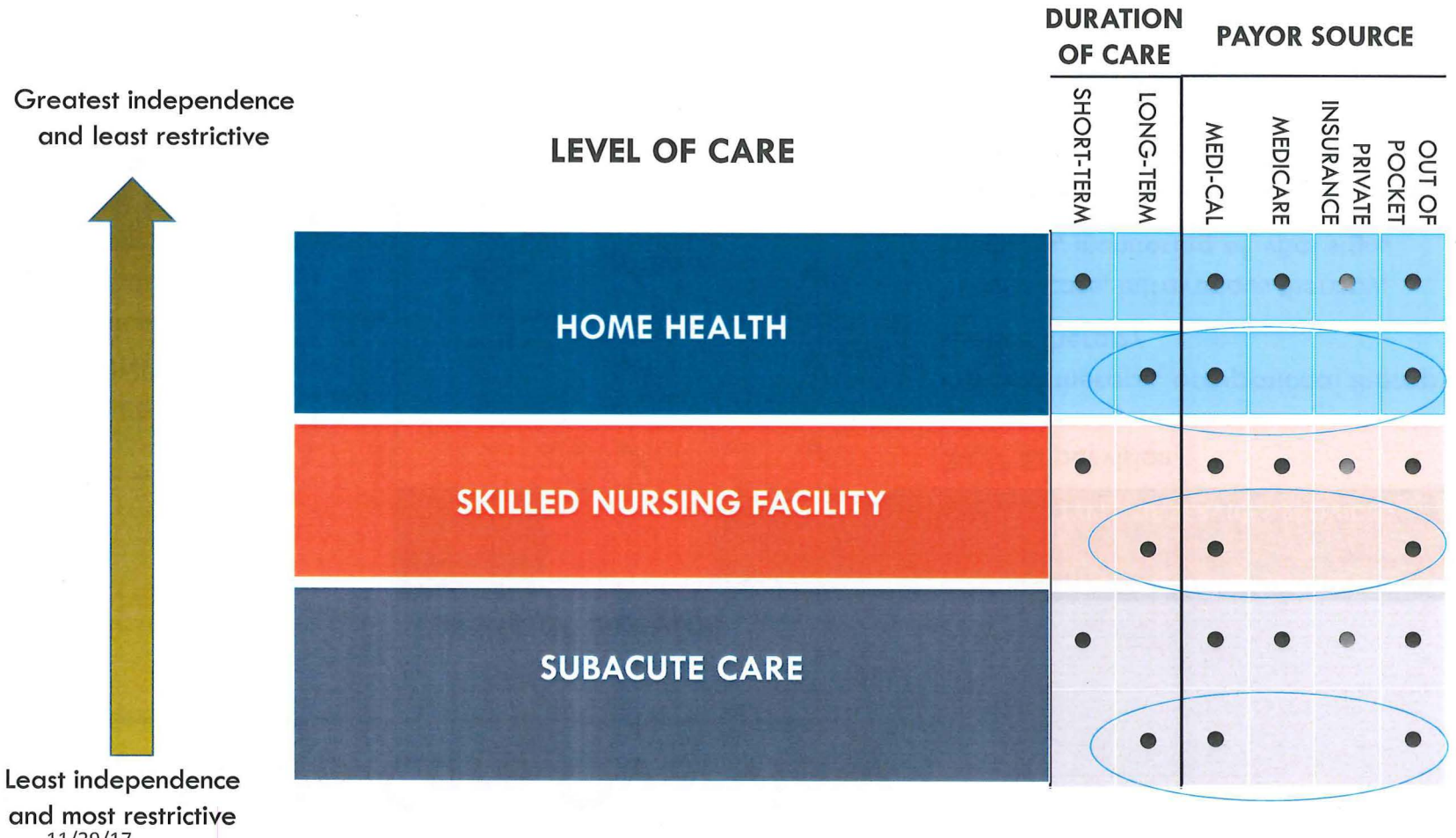
GENERAL DEFINITION
medical services that support recovery from illness following a hospitalization

Levels of Service

HOME HEALTH*	SKILLED NURSING FACILITY	SUBACUTE**	TYPES OF SERVICES PROVIDED
	✓	✓	24/7 Supervision
✓	✓	✓	Physical therapy, occupational therapy, speech therapy
✓	✓	✓	Wound care, intravenous therapy, injections, monitoring of vital signs
	✓	✓	Assistance with bathing, eating, dressing, feeding, transferring, toilet hygiene
		✓	Ventilator care, complex wound management, intravenous tube feeding

**Home Health Care is provided on a part-time basis*
***Subacute patients are medically fragile and require more intensive care*

Several Factors Impact Post-Acute Care



Access Challenges for Vulnerable Populations

- Low-income populations are challenged when accessing SNF and subacute care largely due to insurance reimbursement policies.
  - Medi-Cal reimbursement is low.
  - Medicare and private health insurance reimburse at higher rates, but only for short-term stays.
  - As a result, facilities are incentivized to serve more short-term patients vs. fewer long-term patients.

- Patients with behavioral needs or without a discharge destination are harder to place

Declining Skilled Nursing Bed Capacity

- Nationally, the number of hospital-based skilled nursing facilities has fallen (63 percent from 1999 to 2013)

- San Francisco has seen a similar decline
  - 30 percent decline in skilled nursing beds since 2003 (from 3,500 licensed beds to 2,439 licensed beds)
  - Largely due to a 43 percent reduction in hospital-based skilled nursing beds

Subacute Care Capacity

- Subacute care can be provided in two types of facilities
  - Short-term Stay: Long-Term Acute Care Hospitals
  - Long-term Stay: Medi-Cal designated Skilled Nursing Facilities

- San Francisco has two facilities that provide subacute care:
  - Kentfield Long-Term Acute Care Hospital - 40-bed facility located at St. Mary's Hospital.
  - CPMC St. Luke's - 40 bed Medi-Cal designated subacute Skilled Nursing Facility

Developing a Post-Acute Care Strategic Plan

- **Objective 1** – Prioritize Aging in Place to Maximize Independence and Support Care in the Least Restrictive Setting

- **Objective 2** – Incentivize Residential Care Facilities for the Elderly and Skilled Nursing Facility Providers to Preserve and Create Beds

- **Objective 3** – Explore Unused Health Care Facility Space that May Provide Opportunities for New Residential Care Facilities and Skilled Nursing Facilities

Developing a Post-Acute Care Strategic Plan (cont.)

- **Incorporating Additional Stakeholder Feedback**
  - Patient and Family Meetings– (December 2017/January 2018)
  - Labor Meeting– (December2017/January 2018)
- **Aligning Several Related Efforts**
  - Post-Acute Care Collaborative (December 2017)
  - Health Care Services Master Plan (Spring 2018)
  - Regional efforts with San Mateo County (ongoing)
  - Local implementation of Medi-Cal Home and Community Based Waivers (ongoing)
- **Collaborating with Multiple Partners**
  - Collaborating with the Department of Aging & Adult Services
  - Coordinating with healthcare partners
- **Finalizing a Post-Acute Care Strategic Plan** (Spring 2018)

Thank You